MISSISSIPPI DIVISION OF MEDICAID

MississippiCAN Program Design Summary

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Introduction

Program Goals

The implementation of Mississippi Coordinated Access Network (MississippiCAN), a Coordinated Care Program for Mississippi Medicaid beneficiaries, will address the following goals:

- **Improve access to needed medical services -** This goal will be accomplished by connecting the targeted beneficiaries with a medical home, increasing access to providers and improving beneficiaries' use of primary and preventive care services.
- **Improve quality of care –** This goal will be accomplished by providing systems and supportive services, including disease state management and other programs that will allow beneficiaries to take increased responsibility for their health care.
- **Improve efficiencies and cost effectiveness** – This goal will be accomplished by contracting with Coordinated Care Organizations (CCOs) on a full-risk capitated basis to provide comprehensive services through an efficient, cost effective system of care.

Section A: Program Description

Part I: Program Overview

A. 1915(b) Federal Waiver Authority

Mississippi will seek a Federal Medicaid 1915(b) waiver to secure approval to implement a care coordination program for targeted beneficiaries.

B. Program Geographic Areas

MississippiCAN will be implemented in all 82 counties in the state of Mississippi for all eligible beneficiaries beginning October 1, 2009.

C. Target Population

The target population of MississippiCAN is comprised of four groups, including:

- Pregnant women;
- Children under the age of one year;
- Targeted, high cost Medicaid beneficiaries are defined as those individuals in a category of eligibility that has been as determined by claims review to have an above average per member per month cost and more than 1,200 member months in the category. Therefore, the targeted, high cost Medicaid beneficiaries covered in this program are
    - SSI,
    - Disabled Child at Home,
    - Working Disabled,
    - Department of Human Services Foster Care, and
    - Breast/Cervical Group

Persons in an institution such as a nursing facility, ICF/MR or PRTF; dual eligibles (Medicare and Medicaid); and waiver members are excluded from the program regardless of the category of eligibility.

D. Mandatory Enrollment

The enrollment into MississippiCAN of the targeted populations will be mandatory. There will be no ability to opt out of the program.

All beneficiaries will have the ability to choose the CCO of their choice. Enrolled beneficiaries will have an open enrollment period during the 90 days following their initial enrollment in a CCO during which they can enroll in a different CCO "without cause," and an open enrollment period at least once every 12 months after the initial date. This will align with the timing of each beneficiary's annual eligibility redetermination date (except for the initial enrollment group since that will occur on October1 for all). At each beneficiary's annual eligibility redetermination, beneficiaries may choose to select another CCO.

Various "for cause" reasons for disenrollment at other times will incorporate federal requirements, such as: providers that do not (for religious or moral reasons) offer needed services; not all related services are available in the plan's network; or the plan lacks providers experienced in dealing with the enrollee's health care needs.

Eligibility criteria for MississippiCAN will be the same as the eligibility criteria for Mississippi Medicaid.

Children enrolled in MississippiCAN will have 12 months of continuous Medicaid eligibility and beneficiaries over 19 years of age will have eligibility determined annually.

The CCOs will not have the ability to directly market to the targeted beneficiaries. The Division of Medicaid (DOM) will be responsible for creating a process to provide information about choice of CCOs and enroll the beneficiaries into their chosen CCO. DOM staff and the Medicaid Fiscal Agent will work together to accomplish these tasks. No separate enrollment broker will be procured.

The enrollment process will ensure that beneficiaries have informed choice, the process is cost efficient and timely, and the process is acceptable to advocates, providers and beneficiaries.

E. Members' Rights and Protections

Members' rights and protections will be required, including the right to:

- receive needed information about the program;
- be treated with respect, dignity and privacy;
- receive information on available treatment options; participate in health care decisions;
- request copies of medical records; and
- be furnished services with an adequate delivery network, timely access, coordination and continuity of care, and other specified standards.

Members' protections will also be provided through access standards, care coordination requirements, quality management programs, and detailed grievance and appeals procedures.

F. Coordinated Care Organizations

To meet goals of choice for beneficiaries, financial stability of the program and administrative ease, DOM is recommending no more than three CCOs be awarded a contract to administer a Care Coordination program.

CCOs will be required to bid on the entire state and provide, at a minimum, the comprehensive package of Mississippi Medicaid services (excluding mental health and non-emergency transportation) to all targeted populations. CCOs must have at least five years of experience with a Medicaid program. In regard to licensure, CCOs must: (1) be licensed by the Mississippi Department Insurance; or (2) in the process of obtaining a license by the Mississippi Department of Insurance to be effective by October 1, 2009 and licensed in another state.

CCOs will receive prepaid monthly capitated payments and will provide services through a full-risk arrangement.

Part II: Major Program Elements

A. Benefits

A comprehensive package of services will be provided by the CCOs that include, at a minimum, the current Mississippi Medicaid benefits. CCOs will not be responsible for behavioral health services. These services will be provided by community mental health centers. However, psychotropic medications will be provided by CCOs because many of these medications are prescribed by primary care physicians. Non-emergency transportation will continue to be provided by DOM's current contractor.

The CCOs must require beneficiaries to have a wellness physical exam annually. This will ensure that the CCO has a baseline of enrollee's health status, allowing CCOs to measure change and coordinate care appropriately by developing a health and wellness plan and identifying interventions to improve outcomes.

B. Administrative Services

CCOs will be required to demonstrate that they have the information systems in place to meet all of the operating and reporting requirements of their proposed program, as well as all of the reporting requirements of DOM, including collecting and pursuing third party liability payments.

CCOs will be required to operate both member and provider call centers. The member call center must be available to members 24 hours a day, seven days a week. The provider call center must operate during normal providers' business hours.

CCOs will be responsible for processing claims. DOM will establish minimum standards for financial and administrative accuracy and for timeliness of processing; these standards will be no less than the standards currently in place for the Medicaid fee-for-service program. CCOs will be required to submit complete encounter data to DOM that meets federal requirements and allows DOM to monitor the program. CCOs that do not meet standards will be penalized.

CCOs will be responsible for maintaining an Administrative Office within 15 miles of Jackson. This office will provide space for DOM staff to work when monitoring MississippiCAN.

C. Provider Network

The "provider network" is the panel of health service providers with which the CCO contracts for the provision of covered services to beneficiaries. All CCO contracted providers must also be enrolled in the Mississippi Medicaid program. CCOs will be required to recruit a provider network that includes all types of Medicaid providers and the full range of medical specialties necessary to provide the covered benefits, including contracts with out-of-state providers for medically necessary services. In establishing its provider network, CCOs will be required to contract with FQHCs and RHCs. Access standards for the provider network will require the CCOs to insure that for primary care services members travel no more than 60 minutes or 60 miles in the rural regions and 30 minutes or 30 miles in the urban regions.

As access to non-hospital based emergency care is an issue of concern, CCOs will be required to include non-hospital urgent and emergent care providers in their networks.

D. Care Management

The CCOs are expected to participate as partners with providers and beneficiaries in arranging for the delivery of health care services that improve health status in a cost effective way. DOM expects CCOs to connect beneficiaries to a medical home and implement comprehensive care management programs for the targeted populations. Care management will include a method to coordinate services with behavioral health providers, social services agencies and out-of-state providers to improve care and quality outcomes.

CCOs will be required to develop disease state management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, hemophilia, organ transplants, and improved birth outcomes.

All CCO's will be expected to have a comprehensive health education program that will support the disease management programs.

CCOs will develop a comprehensive utilization management program to ensure the medical necessity of all services provided.

E. Quality Assurance

CCO quality assurance programs should assess actual performance to ensure that beneficiaries are receiving medically appropriate care on a timely basis that results in positive or improved outcomes. Complaint resolution and grievance processes are components of an effectively integrated quality assurance program and therefore will be included.

CCO quality assurance programs are expected to identify opportunities for improved quality and initiate programs that achieve improvements by using evidence based medicine and practice guidelines. These activities include using data to establish baselines, measure performance, identify performance improvement opportunities, and create member and provider profiles.

CCOs will commit to supporting the use of electronic medical records in provider offices to promote efficient coordinated care that will ultimately result in improved outcomes.

Part III: Rate Setting

Capitated Coordinated Care Rates

DOM will contract with the CCOs using a full-risk arrangement that will pay each CCO a prepaid monthly capitation rate to cover all services included in the CCO contract. DOM will develop cost-effective and actuarially sound rates according to all applicable CMS rules and regulations. DOM will develop monthly capitation rates that will be offered to CCOs on a "take it or leave it" basis.

The **draft** rate structure is shown below:

Pregnant women

DOM will pay the CCOs a maternity "kick payment" (i.e., an all-inclusive case rate) for all hospital and physician delivery-related services. Many other Medicaid programs use a kick payment arrangement to pay plans for maternity services under their programs to protect CCOs from late term enrollment. DOM will pay a monthly capitation rate for all services not related to a delivery.

Children under one year of age

DOM will develop monthly capitation rates that vary by age to reflect the difference in expected cost by age.

- Age 0 – 2 months
- Age 3 – 11 months

DOM will develop an arrangement to share risk with the CCOs for NICU babies. The risk sharing program will provide clear financial incentives for the CCOs to manage the cost and outcomes of NICU babies.

Targeted high cost populations

DOM will develop monthly capitation rates that vary by age to reflect the difference in expected cost by age

- Age 1 – 5 years
- Age 6 – 20 years
- Age 21 years and older

Regional/geographic rates

DOM will research cost of care in different regions of Mississippi to determine if material cost differences exist. DOM will consider offering regional rates to better reflect CCO enrollment for CCOs that enroll a disproportionate number of beneficiaries from high-cost or low-cost regions of the state.

In general, the capitation rates will be developed using fee-for-service data for the eligible populations from state fiscal years 2007 and 2008 and the following adjustments:

- Utilization trend
- Unit cost trend
- Medicaid program changes
- Incurred but not reported claims and third party liability recoveries
- Coordinated care savings
- CCO administrative allowance

Section B: Contract Award Timeline

Contract Award Timeline

With the currently proposed implementation date of October1, 2009, the following is the projected high level timeline:

RFP Released	January 27, 2009
Conference for Data Book Review	February 5, 2009
Letter of Intent to Submit Proposal due to DOM	February 9, 2009
Questions from Proposers due to DOM	February 9, 2009
Responses from DOM Released	February 16, 2009
Proposals from CCOs due to DOM	March 16, 2009
Implementation	October 1, 2009

Section C: Contract Compliance and Monitoring

Contract Compliance and Monitoring

A critical component of MississippiCAN is contract compliance and monitoring to ensure that the goals of the program are being met. DOM will assess the performance of the selected CCOs prior to and after the October2009 implementation.

DOM will complete readiness reviews of CCOs prior to implementation of MississippiCAN on October1, 2009. This includes evaluation of all CCO program components including IT, administrative services and medical management. Each readiness review will take approximately three weeks and be performed on site at CCOs' administrative offices.

DOM will ensure that MississippiCAN conforms to 1915(b) federal waiver requirements as listed below.

- Program Impact – choice, marketing, enrollment/disenrollment, program integrity, information to beneficiaries, and grievance systems
- Access – timely access, PCP/specialist capacity, and coordination and continuity of care
- Quality – coverage and authorization, provider selection, and quality of care

DOM will audit the performance of the CCOs against contract requirements. The audit will include all aspects of the program that are over and above the waiver requirements and financial expectations.

DOM will closely monitor the financial performance of contractors. DOM will require CCOs to submit quarterly and annual reports that will allow DOM to assess CCO claims reserves and overall financial soundness.

DOM will require quarterly reports on claims processing and encounter submission. DOM will impose penalties for failure to meet established standards.

When DOM establishes that a CCO is out of compliance with any of the above monitoring activities, the CCO will be required to provide corrective action plans to ensure that the goals of the program will be met.